PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ______________________________

G Prescription Information within the Last Twelve (12) Months – Separate Sheet

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Name of Individual:

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (________)______________________ City & State ______________________

Name of Individual:

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (________)______________________ City & State ______________________

Name of Individual:

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (________)______________________ City & State ______________________

Name of Individual:

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (________)______________________ City & State ______________________

Name of Individual:

Name of Medication: ______________________

Reason for Taking: ______________________

First & Last Treatment Date: ______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________

Phone # (________)______________________ City & State ______________________

Signature: ______________________ Date: ______________